

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11218

11237

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|---|------------------------------|---|--|--|---|---|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER, MD.</u> | | c. LENGTH OF STAY IN 1b <u>30 YEARS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RD #3</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AT HOME</u> | | | | d. STREET ADDRESS <u>MANCHESTER ROAD</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>GENERAL KEMPER ARMENTROUT</u> | | | | 4. DATE OF DEATH Month Day Year <u>Oct. 15 1959</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>AUG. 12, 1875</u> | | 9. AGE (In years last birthday) <u>84</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREMAN ON PENNSYLVANIA R.R.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>VIRGINIA</u> | | 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>PATRICK N. ARMENTROUT</u> | | | | 14. MOTHER'S MAIDEN NAME <u>SUSAN ??? (ARMENTROUT)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-NO-</u> | | 16. SOCIAL SECURITY NO. <u>-NO-</u> | | 17. INFORMANT Address <u>RODGER ECKENROAD - MANCHESTER ROAD, WESTMINSTER, MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>D.S.C.V. disease</u> (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>Months</u> <u>Years</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>James J. Marsh</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>JAMES J. MARSH</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>10/18/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>James G. Saffel - Westminster, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>OCT 19 59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Colburn & Kraus</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|---------------------------|--|--------------------------|--|-----------------------|--|--------------------------|--|------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. OCCUPATION | |
| 6. PLACE OF BIRTH | | 7. DATE OF BIRTH | | 8. DATE OF DEATH | | 9. TIME OF DEATH | | 10. PLACE OF DEATH | |
| 11. CAUSE OF DEATH | | 12. MANNER OF DEATH | | 13. MEDICAL HISTORY | | 14. PRESENT ILLNESS | | 15. TREATMENT | |
| 16. SIGNATURE OF EXAMINER | | 17. SIGNATURE OF WITNESS | | 18. SIGNATURE OF JURY | | 19. SIGNATURE OF CORONER | | 20. SIGNATURE OF CLERK | |

11242

CERTIFICATE OF DEATH

Reg. Dist. No. 11219

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|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Mills</u> | | | | c. LENGTH OF STAY IN 1b <u>1 month</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Meade's Union Convalescent Home</u> | | | | d. STREET ADDRESS <u>230 East Main St</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>HAZEL ELIZABETH BARNES</u> | | | | 4. DATE OF DEATH <u>OCT. 24 1959</u> | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March 26, 1900</u> yrs. | |
| 9. AGE (In years last birthday) <u>59</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>telephone operator retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Williamport, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Peter Ruthrauff</u> | | | | 14. MOTHER'S MAIDEN NAME <u>May Blair</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT <u>John R. Enckart, Westminster, Md.</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension,</u> DUE TO (c) <u>Carcinoma (Uterus)</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 Mo.</u> <u>?</u> <u>5 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>May, 1940</u> , to <u>Oct 24, 1959</u> , that I last saw the deceased alive on <u>Oct. 23, 1959</u> , and that death occurred at <u>7:10 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Wm. C. Jernette</u> M.D. | | | | DATE SIGNED <u>10-24-59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Wm. Carl Jernette M.D.</u> | | | | <u>Westminster Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>10/26/59</u> | | <u>Kraders Cemetery</u> | | <u>Rural, Westminster, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u> | | | | ADDRESS <u>Westminster, Md.</u> | | 24. REC'D BY REGISTRAR <u>Arthur S. Kline</u> | |
| DATE <u>OCT 27 '59</u> | | | | 24b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| NAME OF DECEASED <i>John R. Smith</i> | | DATE OF DEATH <i>April 15, 1954</i> | |
| AGE <i>68</i> | | SEX <i>Male</i> | |
| RACE <i>White</i> | | EDUCATION <i>High School</i> | |
| OCCUPATION <i>Retired</i> | | RESIDENCE <i>1234 Main St, Baltimore, Md</i> | |
| PLACE OF DEATH <i>Home</i> | | CAUSE OF DEATH <i>Heart Disease</i> | |
| IMMEDIATE CAUSE <i>Myocardial Infarction</i> | | INTERMEDIATE CAUSE <i>Coronary Artery Disease</i> | |
| FUNDAMENTAL CAUSE <i>Atherosclerosis</i> | | MANNER OF DEATH <i>Natural</i> | |
| DECEASED'S SIGNATURE <i>John R. Smith</i> | | WITNESSES' SIGNATURES <i>John R. Smith, Jr. and Mary R. Smith</i> | |
| DECEASED'S ADDRESS <i>1234 Main St, Baltimore, Md</i> | | DECEASED'S PHONE <i>555-1234</i> | |
| DECEASED'S BIRTH <i>April 15, 1886</i> | | DECEASED'S BIRTHPLACE <i>Baltimore, Md</i> | |
| DECEASED'S MARRIAGE <i>Married</i> | | DECEASED'S SPOUSE <i>Mary R. Smith</i> | |
| DECEASED'S CHILDREN <i>John R. Smith, Jr. and Mary R. Smith</i> | | DECEASED'S SISTER <i>Mary R. Smith</i> | |
| DECEASED'S BROTHER <i>John R. Smith</i> | | DECEASED'S PARENTS <i>John R. Smith and Mary R. Smith</i> | |
| DECEASED'S GRAVE <i>1234 Main St, Baltimore, Md</i> | | DECEASED'S GRAVE <i>1234 Main St, Baltimore, Md</i> | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3 Film G250 10/27/59, et (See: Birth Cert.)

Reg. Dist. No.

11220

11243

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|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT AIRY | c. LENGTH OF STAY IN 1b 4 yrs. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT AIRY | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ROUTE 4 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Raymond Martin Barthlow Middle Also known as Baby Francis Baby J. Esworthy, III | | 4. DATE OF DEATH Month Oct Day 15 Year 1959 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 1 - 1955 |
| 9. AGE (In years last birthday) 4 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — | | 10b. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME NOT KNOWN | |
| 14. MOTHER'S MAIDEN NAME MARY JANE BARTHLOW | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | |
| 16. SOCIAL SECURITY NO. — | | 17. INFORMANT MRS Francis Esworthy, Jr. Mrs. Mary J. Esworthy | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STATUS EPILEPTICUS 359.2 DUE TO (b) Epilepsy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 4 yrs. | | INTERVAL BETWEEN ONSET AND DEATH 8+ hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE James J. Marsh | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) JAMES J. MARSH | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-17-59 | 22c. NAME OF CEMETERY OR CREMATORY Frederick Memorial Park |
| 22d. LOCATION (City, town, or county) Frederick, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Eshelby | | ADDRESS Frederick, Maryland | |
| 24a. REC'D BY REGISTRAR DATE OCT 19 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

DATE SIGNED

10-15-59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11221

11244

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|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 4 years 25 da. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 910 Whitelock Street | |
| 3. NAME OF DECEASED (Type or print) First Edith Middle Mary (Tyles) Last Beard | | 4. DATE OF DEATH Month 10 Day 3 Year 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-6-1911 |
| 9. AGE (In years last birthday) 48 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Tyles | | 14. MOTHER'S MAIDEN NAME Mary Patecek | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. INFORMANT Address Springfield State Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 237x IMMEDIATE CAUSE (a) Brain Tumor. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 10 years 10 months 18 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain Syndrome associated with new growth with intracranial neoplasm with psychotic reaction. | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from December 1, 19 55 , to October 3, 19 59 , that I lost sow the deceased olive on October 3, 19 59 , and that death occurred at 4:30AM , from the causes ond on the dote stated above. | | | |
| ACTUAL SIGNATURE Jose Flores, M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital | |
| PHYSICIAN'S NAME (Type) Jose Flores, M.D. | | Sykesville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 10-8-59 | 22c. NAME OF CEMETERY OR CREMATORY St. Peters | 22d. LOCATION (City, town, or county) (State) Baltimore |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street | | 24a. REC'D BY REGISTRAR 6-1 7 59 | |
| ADDRESS William Cook, Inc., 1217 St. Paul Street | | 24b. REGISTRAR'S SIGNATURE Curtis A. Howard | |

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CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u> | | c. LENGTH OF STAY IN 1b <u>YEARS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE</u> <u>MARIE</u> <u>BLACK</u> | | 4. DATE OF DEATH Month Day Year <u>OCT 1</u> <u>1959</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>DEC 4-1925</u> |
| 9. AGE (In years last birthday) yrs. <u>33</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>JACOB ALTVATER</u> | | 14. MOTHER'S MAIDEN NAME <u>LYDIA STAUB</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>213-24-9143</u> | |
| 17. INFORMANT <u>ORVILLE BLACK</u> | | Address <u>UNION BRIDGE MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Intestine</u> <u>153.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma obstruction</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs -</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>June 4, 1959</u> , to <u>10-1-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-1-</u> , 19 <u>59</u> , and that death occurred at <u>11:50 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>J. H. Legg</u> M.D. | | DATE SIGNED <u>10-2-59</u> | |
| PHYSICIAN'S NAME (Type) <u>T. H. Legg</u> | | <u>UNION BRIDGE</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>OCT 4-1959</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>ROCKY RIDGE</u> | 22d. LOCATION (City, town, or county) (State) <u>ROCKY RIDGE MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hartzler & Sons</u> | | ADDRESS <u>Union Bridge Md</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>William J. Frank</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

11355

11355

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------|--|--------|--|--------|--|---------|--|------------------|--|-------------------|--|------------------|--|-------------------|--|------------------|--|--------------------|--|---------------------|--|----------------------------|--|--------------------------|--|---------------------------|--|------------------------------|--|----------------------------|--|---|--|--------------------------------|--|----------------------------------|--|------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. TIME OF DEATH | | 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF REGISTRAR | | 13. SIGNATURE OF WITNESS | | 14. SIGNATURE OF DECEASED | | 15. SIGNATURE OF NEXT OF KIN | | 16. SIGNATURE OF PHYSICIAN | | 17. SIGNATURE OF MENTAL HEALTH PROFESSIONAL | | 18. SIGNATURE OF SOCIAL WORKER | | 19. SIGNATURE OF CHURCH OFFICIAL | | 20. SIGNATURE OF OTHER | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

1. This certificate is to be filled out by the registrar of the death.

2. The registrar is the official who is responsible for the registration of deaths.

3. The registrar is the official who is responsible for the registration of deaths.

4. The registrar is the official who is responsible for the registration of deaths.

5. The registrar is the official who is responsible for the registration of deaths.

6. The registrar is the official who is responsible for the registration of deaths.

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12. The registrar is the official who is responsible for the registration of deaths.

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14. The registrar is the official who is responsible for the registration of deaths.

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16. The registrar is the official who is responsible for the registration of deaths.

17. The registrar is the official who is responsible for the registration of deaths.

18. The registrar is the official who is responsible for the registration of deaths.

19. The registrar is the official who is responsible for the registration of deaths.

20. The registrar is the official who is responsible for the registration of deaths.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11223

11246

| | | | | | | | |
|---|------------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE | | | | c. LENGTH OF STAY IN 1b YEARS | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ROGER THOMAS BOONE | | | | 4. DATE OF DEATH Month Day Year OCT 9 1959 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH NOV 6 - 1902 | | 9. AGE (In years last birthday) 56 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UPHOLSTER | | 10b. KIND OF BUSINESS OR INDUSTRY RAILROAD | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME HANSON BOONE | | | | 14. MOTHER'S MAIDEN NAME SARAH WELKER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 705-10-6020 | | 17. INFORMANT Address RUTH BOONE UNION BRIDGE MD | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound abdomen DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 976X (c) min. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.) Gunshot wound, self-inflicted | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 12:30 a.m. 10-9 1959 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) Union Bridge Carroll Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE James T. Marsh | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 10/9/59 | |
| EXAMINER'S NAME (Type) JAMES T. MARSH | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10/12/59 | | 22c. NAME OF CEMETERY OR CREMATORY LUTHERAN | | 22d. LOCATION (City, town, or county) (State) UNIONTOWN MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS DD Hutzler & Sons Union Bridge Md | | | | 24a. REC'D BY REGISTRAR DATE OCT 13 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur J. Kline | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|-------------------------------------|--|-------------------------------------|--|--|--|
| NAME OF DECEASED [Illegible] | | SEX [Illegible] | | AGE [Illegible] | |
| PLACE OF BIRTH [Illegible] | | OCCUPATION [Illegible] | | DATE OF DEATH [Illegible] | |
| TIME OF DEATH [Illegible] | | PLACE OF DEATH [Illegible] | | CAUSE OF DEATH [Illegible] | |
| MANNER OF DEATH [Illegible] | | MEDICAL HISTORY [Illegible] | | PRESENT ILLNESS [Illegible] | |
| SIGNS AND SYMPTOMS [Illegible] | | PHYSICAL EXAMINATION [Illegible] | | LABORATORY EXAMINATIONS [Illegible] | |
| POST-MORTEM FINDINGS [Illegible] | | GROSS FINDINGS [Illegible] | | MICROSCOPIC FINDINGS [Illegible] | |
| OTHER FINDINGS [Illegible] | | COMMENTS [Illegible] | | SIGNATURE OF EXAMINER [Illegible] | |
| DATE OF EXAMINATION [Illegible] | | PLACE OF EXAMINATION [Illegible] | | OFFICIAL USE [Illegible] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11224

11247

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 5yrs.1mo.18days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Nellie Middle Tayman Last Brouss | | 4. DATE OF DEATH Month October Day 21 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 10, 1879 |
| 9. AGE (In years last birthday) 80 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine worker | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown - | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Edward Tayman | | 14. MOTHER'S MAIDEN NAME Sara Elizabeth | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S.assoc.with circ.dist.,with cerebral arteriosclerosis with psychotic reaction. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 3, 1955 , to October 21, 1959 , that I last saw the deceased alive on October 20, 1959 , and that death occurred at 12:20AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Agustin del Campo</i> | | ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 10/21/59 | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | Sykesville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/24/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Peters Cem. | | 22d. LOCATION (City, town, or county) (State) Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Dickner & Sons - Balt.</i> | | 24a. REC'D BY REGISTRAR DATE OCT 23 '59 | |
| 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | | |

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

References

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Степанов: 278

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doi:10.1017/S002229240000209

DATE: 10/10/2003

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AT5 (4)
ISM 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11248
CERTIFICATE OF DEATH

11225

Reg. Dist. No.

| | | | |
|---|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN lb 2yrs.5mos.16days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6 3V01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 5709 Belair Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Josephine Middle Burns Last Burns | | 4. DATE OF DEATH Month October Day 30, Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 30, 1892 |
| 9. AGE (In years last birthday) 67 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music teacher | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Burns | | 14. MOTHER'S MAIDEN NAME Mary Ann Mitchel | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - | | 16. SOCIAL SECURITY NO. - INFORMANT Address Springfield Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction. | | INTERVAL BETWEEN ONSET AND DEATH Years Years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from November 11, 1958 , to October 30, 1959 , that I last saw the deceased alive on October 30, 1959 , and that death occurred at 9:00P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Francesco Magro M.D. | | ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/31/59 | |
| PHYSICIAN'S NAME (Type) Francesco Magro, M.D. | | Sykesville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 11-3-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck | | ADDRESS 5305 Harford Rd. | |
| 24a. REGISTRY REGISTAR'S SIGNATURE NOV 3 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur J. Ruck | |

10

11249

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shapsville md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Westminster,</u> | |
| *d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carlton Nursing Home</u> | | d. STREET ADDRESS <u>Ward Ave</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>LELIA</u> LELIA Middle <u>BELL</u> Last <u>CARTER</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>14</u> Year <u>1959</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OF RACE <u>N.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 13, 1880</u> 79 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Isaac Mullon</u> | | 14. MOTHER'S MARDEN NAME <u>Rose Widows</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u> | | 16. SOCIAL SECURITY NO. <u>no.</u> | |
| 17. INFORMANT <u>Mrs. Marie H. Elough</u> | | Address <u>196 E. Green St</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE, DIABETES,</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis generalized-</u> DUE TO (c) <u>uterine fibroids - Chronic Brain Syndrome</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1958</u> <u>to</u> <u>14 OCT 59</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>1958</u> , 19 <u>58</u> , to <u>14 OCT</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>14 OCT</u> , 19 <u>59</u> , and that death occurred at <u>5:15 P</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D. | | ADDRESS (Street, city or town, state) <u>Agnewville, Md</u> DATE SIGNED <u>14 OCT 59</u> | |
| PHYSICIAN'S NAME (Type) _____ | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10/17/59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u> | 22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> |
| 23. FUNERAL-DIRECTOR'S SIGNATURE <u>Loring Byers</u> ADDRESS <u>8728 Liberty Rd. Randallstown, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 21 '59</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

11250

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|---|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore ✓ | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | c. LENGTH OF STAY IN 1b 4mos. 24 days | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Leo Middle Joseph Last Cummings | | | 4. DATE OF DEATH Month October Day 19 Year 1959 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 10, 1886 | 9. AGE (In years lost birthday) yrs. 73 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney | | | 10b. KIND OF BUSINESS OR INDUSTRY - | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME John Cummings | | | 14. MOTHER'S MAIDEN NAME Johanna Heaphy | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - | | | 16. SOCIAL SECURITY NO. - | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. | | | INTERVAL BETWEEN ONSET AND DEATH Years Years | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from May 25, 19 59 to October 19 , 19 59 , that I last saw the deceased alive on October 19, 19 59 , and that death occurred at 6:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/20/59 ACTUAL SIGNATURE Agustin del Campo M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF OCT-23, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL BALTIMORE MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W M COOK - TOWSON 1000 YORK RD - TOWSON | | ADDRESS 4 MD | | 24a. REC'D BY REGISTRAR OCT 22 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

11-27

CERTIFICATE OF DEATH

11280



MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

NAME: [illegible] SEX: [illegible] AGE: [illegible] DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible] OCCUPATION: [illegible]

DATE OF DEATH: [illegible] TIME OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

SIGNATURE OF PHYSICIAN: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE OF ENTRY: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G251 11-13-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

11228

11251

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|---|--|----------------------------------|--|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 1Y 9M 16D d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville d. STREET ADDRESS Mineral Hill Road Route 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First JOSEPH Middle SAMUEL Last DUNN | | | | 4. DATE OF DEATH Month October Day 31 Year 1959 | | | | | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-7-75 | | 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothing cutter (rtd) | | | | 10b. KIND OF BUSINESS OR INDUSTRY Shirt Mfg. | | | | 11. BIRTHPLACE (State or foreign country) Unknown Md. | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME T. Samuel / Dunn | | | | 14. MOTHER'S MAIDEN NAME Unknown Catherine Carlisle | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. Records of Springfield State Hospital | | | | 17. INFORMANT Address Records of Springfield State Hospital | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Pneumonia and CBS ass. with senile brain disease | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 10-14-58 , 19 58 , to 10-30 , 19 59 , that I last saw the deceased alive on 10-30 , 19 59 , and that death occurred at 6:15A AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED Myron Nizankowski M.D. ACTUAL SIGNATURE Myron Nizankowski PHYSICIAN'S NAME (Type) Myron Nizankowski Sykesville, Maryland | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 11/3/59 | | 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | | | | 22d. LOCATION (City, town, or county) (State) Pikesville, Md. | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lieber ADDRESS 4 Low-Belle, 17th | | | | | | 24a. REC'D BY REGISTRAR DATE 2 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hanes | | | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11238

CERTIFICATE OF DEATH

Reg. Dist. No.

11229

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|---|-------------------------------|--|---------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER | | | | c. LENGTH OF STAY IN 1b 30 YEARS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 189 PENNA. AVE. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) ELLA MAY DUTTERER | | | | 4. DATE OF DEATH OCTOBER 16 1959 | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCT. 14, 1892 | 9. AGE (In years last birthday) 67 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Westminster, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frank A. Shipley | | | | 14. MOTHER'S MAIDEN NAME Sarah Lavinia Wagner | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) - | | 17. INFORMANT M. Chas. J. Dutton, Westminster, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) - | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 HOURS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on OCTOBER 16, 1959 , and that death occurred on OCT 17 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 19 Ridge Rd. Westminster, Md. DATE SIGNED 10/16/59 | | | | | | | |
| ACTUAL SIGNATURE Daniel I. Welliver M.D. | | | | PHYSICIAN'S NAME (Type) Daniel I. Welliver, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF OCT. 19. 59 | | 22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery Westminster, Md. | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr., Westminster, Md. | | | | 24a. REC'D BY REGISTRAR OCT 20 '59 | | 24b. REGISTRAR'S SIGNATURE Carlton E. Hume | |

CERTIFICATE OF DEATH

11527

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|---|--|---|--|
| <p>1. NAME OF DECEASED ALVIN</p> | | <p>2. SEX M</p> | |
| <p>3. AGE 34</p> | | <p>4. DATE OF BIRTH 10-15-1912</p> | |
| <p>5. PLACE OF BIRTH BALTIMORE, MARYLAND</p> | | <p>6. OCCUPATION LABORER</p> | |
| <p>7. MARITAL STATUS SINGLE</p> | | <p>8. CAUSE OF DEATH HEART DISEASE</p> | |
| <p>9. MANNER OF DEATH NATURAL</p> | | <p>10. PLACE OF DEATH HOME</p> | |
| <p>11. DATE OF DEATH 11-15-1946</p> | | <p>12. TIME OF DEATH 10:30 AM</p> | |
| <p>13. SIGNATURE OF DECEASED ALVIN</p> | | <p>14. SIGNATURE OF WITNESS ALVIN</p> | |
| <p>15. SIGNATURE OF PHYSICIAN ALVIN</p> | | <p>16. SIGNATURE OF CORONER ALVIN</p> | |
| <p>17. SIGNATURE OF REGISTRAR ALVIN</p> | | <p>18. SIGNATURE OF CLERK ALVIN</p> | |

RECEIVED
 BALTIMORE, MARYLAND
 NOV 16 1946
 DEPARTMENT OF HEALTH

11252

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Carroll | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 6 mos. 24 da. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS 4904 DeRussey Parkway | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Rose Middle Erdman Last Erdman | | | | 4. DATE OF DEATH Month October Day 14 Year 19 59 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 4, 1871 | 9. AGE (In years last birthday) 88 yrs. | IF UNDER 1 YEAR Months 14 Days 19 Hours 59 | IF UNDER 24 HRS. Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher, Retired, Public Schools | | | | 10b. KIND OF BUSINESS OR INDUSTRY Balto, Md. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Francis S. Erdman | | | | 14. MOTHER'S MAIDEN NAME Mary Gravas Erdman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. none | | | |
| 17. INFORMANT Springfield State Hospital | | | | 18. ADDRESS Hospital Record Sykesville, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Days Years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with cerebral arteriosclerosis with psychotic reaction. | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from March 20, 19 59 , to October 14, 19 59 that I last saw the deceased alive on October 14, 19 59 , and that death occurred at 11:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital Sykesville, Maryland DATE SIGNED October 15, 1959 | | | | | | | |
| ACTUAL SIGNATURE Ilse Kamm M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Ilse Kamm, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| 10/17/1959 | | Druid Ridge Cemetery | | Baltimore, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W. | | | | 24a. REC'D BY REGISTRAR OCT 19 59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kious | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11231

11253

Reg. Dist. No.

| | | | | | |
|--|----------------------------------|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown | | c. LENGTH OF STAY IN 1b 25 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS 11 Fairview Ave. | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Louise Last Essig | | | 4. DATE OF DEATH Month October Day 6 Year 19 59 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 25, 1927 | | 9. AGE (In years last birthday) 32 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician | | 10b. KIND OF BUSINESS OR INDUSTRY Own shop | | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Edgar Essig | | | 14. MOTHER'S MAIDEN NAME Minnie E. Stratton | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 216-22-9156 | | 17. INFORMANT J. Darrell Nelson, Taneytown, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <i>James T Marsh</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 10/6/59 | |
| EXAMINER'S NAME (Type) JAMES T MARSH | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/8/59 | | 22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery | |
| | | | | 22d. LOCATION (City, town, or county) (State) Taneytown, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>C.O. Fuss</i> C.O. Fuss & Son, Taneytown, Maryland | | 24a. REC'D BY REGISTRAR OCT 8 '59 | | 24b. REGISTRAR'S SIGNATURE <i>Arthur E. Evans</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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COMPLAINTS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 3, 11, 12 Film G251 11-16-59 et
11254 CERTIFICATE OF DEATH

11232
Reg. Dist. No.

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sikesville</u> c. LENGTH OF STAY IN 1b <u>12 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hosp.</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>901 Chestnut Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Isabel</u> Middle <u>Fesler</u> Last <u>FRANKEN</u> | | 4. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>1959</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-23-85</u> |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>19</u> Min. <u>59</u> | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>John Fridinger</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Lushbaugh</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | |
| 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Hospital record</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, arteriosclerosis, diabetes</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify, that I attended the deceased from <u>10-5</u> , 19 <u>59</u> , to <u>10-17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-17</u> , 19 <u>59</u> , and that death occurred at <u>3:30 p. M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Dr. Kamm</u> | | ADDRESS (Street, city or town, state) <u>Sikesville Md</u> DATE SIGNED <u>10-17-59</u> | |
| PHYSICIAN'S NAME (Type) <u>LEIF KAMM</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>10/20/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Hoyer</u> | | ADDRESS <u>HAGERSTOWN, MD.</u> | |
| 24a. REC'D BY REGISTRAR <u>NOV 10 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u> | |

11803

CERTIFICATE OF DEATH

11804

| | | | | | | | | | | | |
|------------------------|--|------------------------|--|-----------------------|--|---------------------------|--|--------------------|--|--------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | | PLACE OF DEATH | |
| | | | | | | | | | | | |
| CAUSE OF DEATH | | MANNER OF DEATH | | OCCUPATION | | EDUCATION | | RELIGION | | MARITAL STATUS | |
| | | | | | | | | | | | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | | SIGNATURE OF FUNERAL HOME | | SIGNATURE OF CLERK | | SIGNATURE OF JUDGE | |
| | | | | | | | | | | | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11255

CERTIFICATE OF DEATH

11233

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster | | | | c. LENGTH OF STAY IN 1b Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R. D. 7 | | | | e. STREET ADDRESS Westminster, Md. R. D. 7 | | | |
| 3. NAME OF DECEASED (Type or print) First Roxie Middle Viola Last Fleischman | | | | 4. DATE OF DEATH Month 10/22/59 Day 19 Year 19 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5/26/1889 | |
| 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0 | | IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Housework | | | | 10b. KIND OF BUSINESS OR INDUSTRY The family home | | 11. BIRTHPLACE (State or foreign country) Carroll Co., Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Wesley Zepp | | | | 14. MOTHER'S MAIDEN NAME Rebecca Heltibridle | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 171X | | | |
| 17. INFORMANT Mrs. William J. Humbert, Westminster, Md. R-7 | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Cervix DUE TO (b) & Metastases Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Anemia & Cachexia DUE TO (c) Anemia & Cachexia | | | | | | INTERVAL BETWEEN ONSET AND DEATH Several months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Oct 17 , 19 59 , to Oct 22 , 19 59 , that I last saw the deceased alive on Oct 21 , 19 59 , and that death occurred at 6:55 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Wesley Zepp | | | | ADDRESS (Street, city or town, state) Westminster, Md. | | | |
| PHYSICIAN'S NAME (Type) Wesley Zepp | | | | DATE SIGNED 10/23/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/24/59 | | 22c. NAME OF CEMETERY OR CREMATORY Bixlers Cemetery | | 22d. LOCATION (City, town, or county) (State) Bachmans Valley, Carroll Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little | | | | ADDRESS Littlestown, Pa. | | 24a. REC'D BY REGISTRAR DATE OCT 26 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Evans | | | | | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | |
|-------------------------------------|--|----------------------------------|--|---|--|---|--|--------------------------------------|--|
| NAME OF DECEASED JAMES H. HARRIS | | AGE 45 | | SEX Male | | RACE White | | DATE OF DEATH April 15, 1945 | |
| PLACE OF DEATH Home | | CITY OR TOWN Baltimore | | COUNTY Baltimore | | STATE Maryland | | ZIP CODE 21201 | |
| MANNER OF DEATH Natural | | CAUSE OF DEATH Heart Disease | | IMMEDIATE CAUSE Myocardial Infarction | | INTERMEDIATE CAUSE Coronary Artery Disease | | FUNDAMENTAL CAUSE Atherosclerosis | |
| EDUCATION High School | | OCCUPATION Salesman | | MARITAL STATUS Married | | RELIGION Roman Catholic | | SINGLE OR MARRIED MARRIED | |
| BIRTH DATE April 15, 1900 | | BIRTH PLACE Baltimore, Md. | | PARENTS John H. Harris, Father Mary E. Harris, Mother | | SIBLINGS None | | PREVIOUS MARRIAGES None | |
| DATE OF BIRTH April 15, 1900 | | PLACE OF BIRTH Baltimore, Md. | | PARENTS John H. Harris, Father Mary E. Harris, Mother | | SIBLINGS None | | PREVIOUS MARRIAGES None | |
| DATE OF DEATH April 15, 1945 | | PLACE OF DEATH Home | | CITY OR TOWN Baltimore | | COUNTY Baltimore | | STATE Maryland | |
| MANNER OF DEATH Natural | | CAUSE OF DEATH Heart Disease | | IMMEDIATE CAUSE Myocardial Infarction | | INTERMEDIATE CAUSE Coronary Artery Disease | | FUNDAMENTAL CAUSE Atherosclerosis | |
| EDUCATION High School | | OCCUPATION Salesman | | MARITAL STATUS Married | | RELIGION Roman Catholic | | SINGLE OR MARRIED MARRIED | |
| BIRTH DATE April 15, 1900 | | BIRTH PLACE Baltimore, Md. | | PARENTS John H. Harris, Father Mary E. Harris, Mother | | SIBLINGS None | | PREVIOUS MARRIAGES None | |

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTER OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE HEALTH COMMISSIONER, BALTIMORE, MARYLAND.

REGISTERED
APR 15 1945

HEALTH COMMISSIONER
BALTIMORE, MARYLAND

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH

11258

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for a burial, cremation or removal.

VS. A15ME(5)
5M 9/55

| Item 20 Film 230 10-19-59 | | | | | | | | | | 11257 | | | | | | | | | | 11235 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> | | | | | | | | | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead Rural</i> | | | | | | | | | | c. LENGTH OF STAY IN 1b <i>15 yrs</i> | | | | | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Hampstead Rural</i> | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>✓</i> | | | | | | | | | | j. STREET ADDRESS <i>✓</i> | | | | | | | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>C-ATLEE-FOWBLE</i> First Middle Last | | | | | | | | | | 4. DATE OF DEATH <i>Oct 8 1959</i> Month Day Year | | | | | | | | | | | | | | | | | | | |
| 5. SEX <i>M</i> | | | | | | | | | | 6. COLOR OR RACE <i>W</i> | | | | | | | | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | |
| 8. DATE OF BIRTH <i>June 15-1876</i> | | | | | | | | | | 9. AGE (In years last birthday) <i>83</i> yrs. | | | | | | | | | | IF UNDER 1 YEAR Months Days Hours Min. | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Harmon</i> | | | | | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>own farm</i> | | | | | | | | | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | | | | | | | | |
| 12. CITIZEN OF WHAT COUNTRY? <i>W.S.A</i> | | | | | | | | | | 13. FATHER'S NAME <i>Pierce Fowble</i> | | | | | | | | | | 14. MOTHER'S MAIDEN NAME <i>Kate Fowble</i> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | | | | | | | | | 16. SOCIAL SECURITY NO. <i>AN-218-18-3888</i> | | | | | | | | | | 17. INFORMANT <i>Mrs. C. Fowble</i> Address <i>Hampstead Md</i> | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>825X MULTIPLE FRACTURES SKULL</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>825X</i> DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>m</i> | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Automobile Accident</i> | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <i>6:20 p.m. 10 8 1959</i> | | | | | | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Hanover Road</i> | | | | | | | | | | 20f. (City or town) <i>Hampstead</i> (County) <i>Carroll</i> (State) <i>Md.</i> | | | | | | | | | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>James T. Marsh</i> | | | | | | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | DATE SIGNED <i>Oct 8/59</i> | | | | | | | | | |
| EXAMINER'S NAME (Type) <i>JAMES T. MARSH</i> | | | | | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | | | | | | | 22b. DATE THEREOF <i>Oct 14/59</i> | | | | | | | | | | 22c. NAME OF CEMETERY OR CREMATORY <i>Hampstead</i> | | | | | | | | | |
| 22d. LOCATION (City, town, or county) <i>Carroll Co Md</i> | | | | | | | | | | 24a. REC'D BY REGISTRAR <i>Oct 13 '59</i> DATE | | | | | | | | | | 24b. REGISTRAR'S SIGNATURE <i>Arthur E. Frank</i> | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw. E. Nipton</i> | | | | | | | | | | ADDRESS <i>Hampstead Md</i> | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

06

2

251

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G250 10-28-59 et

11236

11258

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gosnell Nursing Home | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3001-4 d. STREET ADDRESS 1 Park Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) MYRTLE F. FRANKLIN | | 4. DATE OF DEATH Month Oct. Day 17, Year 19 59 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 19, 1870 |
| 9. AGE (In years last birthday) 89 yrs. | | IF UNDER 1 YEAR Months 89 Days 17 Hours 19 Min. 59 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY --- | |
| 11. BIRTHPLACE (State or foreign country) Md | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John Sefton | | 14. MOTHER'S MAIDEN NAME Deborah Foutz | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mrs. Roland E. Lane - Wagon Wheel Rd., Glen Arm, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest, Arteriosclerosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized, Arteriosclerotic heart disease, DUE TO (c) Chronic Arterial Syndrome INTERVAL BETWEEN ONSET AND DEATH 1958 40 17 Oct 59 | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9:57 , 19 59 , to 17 Oct , 19 59 , that I last saw the deceased alive on 17 Oct , 19 59 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Howard E. Hall M.D. | | ADDRESS (Street, city or town, state) Apexville, Md DATE SIGNED 17 Oct 59 | |
| PHYSICIAN'S NAME (Type) HOWARD E. HALL | | SYKESVILLE, MD. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/20/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | | 22d. LOCATION (City, town, or county) (State) Woodlawn, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Radio 17 | | 24a. REC'D BY REGISTRAR DATE OCT 21 '59 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kenna | |

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11237

11259

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 29 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 1016 Woodington Rd. | |
| 3. NAME OF DECEASED (Type or print) First Margaret Middle A. Last Fritz | | 4. DATE OF DEATH Month October Day 23 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 7, 1879 |
| 9. AGE (In years last birthday) 80 | | 10. IF UNDER 1 YEAR Months 80 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY O.H. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Blum | | 14. MOTHER'S MAIDEN NAME Mary Snag | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Address Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Schizophrenia, paranoid type. Fracture, left femur. | | INTERVAL BETWEEN ONSET AND DEATH Days Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 11, 1958 , to October 23, 1959 , that I lost saw the deceased alive on October 23, 1959 , and that death occurred at 8:50A M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Francesco Magro M.D. | | ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/23/59 | |
| PHYSICIAN'S NAME (Type) Francesco Magro, M.D. | | Sykesville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/26/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | | 22d. LOCATION (City, town, or county) (State) Balto. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. | | ADDRESS 4101 Edmondson Ave. | |
| 24a. REC'D BY REGISTRAR DATE OCT 26 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

STATE OF NEW YORK

1938

IN SENATE

January 1, 1938

REPORT OF THE COMMISSIONER OF HEALTH

FOR THE YEAR 1937

ALBANY: J.B. LIPPINCOTT COMPANY, 1938

PRINTED AT THE STATE PRINTING OFFICE

ALBANY, N.Y.

1938

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1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11239

CERTIFICATE OF DEATH

11238

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nursing Home (Jardans)</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>SUSAN REBECCA GIGGARD</u> | | 4. DATE OF DEATH Month Day Year <u>OCT. 27 1959</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 20, 1866</u> |
| 9. AGE (In years last birthday) <u>93</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Andrew Hosfeld</u> | | 14. MOTHER'S MAIDEN NAME <u>Louisa Runkert</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Mrs Ernest L. Crovel, Westminster Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Vascular Renal Disease</u> 442X DUE TO (b) <u>Arterio Sclerosis (Genl)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Similarity</u> INTERVAL BETWEEN ONSET AND DEATH <u>Several hrs</u> Several yrs | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec 28</u> , 19 <u>58</u> , to <u>OCT 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>OCT 28</u> , 19 <u>59</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W. Glenn Speicher, M.D.</u> | | DATE SIGNED <u>10/27/59</u> | |
| PHYSICIAN'S NAME (Type) <u>W. GLENN SPEICHER, M.D. WESTMINSTER, MD.</u> | | ADDRESS (Street, city or town, state) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>OCT. 30, 59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Lanston Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Rural Westminster Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. M... ..</u> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR <u>OCT 29 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles S. K... ..</u> | |

CERTIFICATE OF DEATH

11238

| | | | |
|------------------------|--|------------------------|--|
| PLACE OF DEATH | | MARRIAGE | |
| STREET | | STREET | |
| CITY | | CITY | |
| COUNTY | | COUNTY | |
| STATE | | STATE | |
| DATE OF DEATH | | DATE OF DEATH | |
| HOUR OF DEATH | | HOUR OF DEATH | |
| AGE | | AGE | |
| SEX | | SEX | |
| RACE | | RACE | |
| EDUCATION | | EDUCATION | |
| OCCUPATION | | OCCUPATION | |
| CAUSE OF DEATH | | CAUSE OF DEATH | |
| MANNER OF DEATH | | MANNER OF DEATH | |
| SIGNATURE OF DECEASED | | SIGNATURE OF DECEASED | |
| SIGNATURE OF WITNESS | | SIGNATURE OF WITNESS | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF PHYSICIAN | |
| SIGNATURE OF CLERK | | SIGNATURE OF CLERK | |
| DATE | | DATE | |

RECEIVED
 DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND
 JAN 10 1918

CERTIFICATE OF DEATH

Reg. Dist. No.

11239

11260

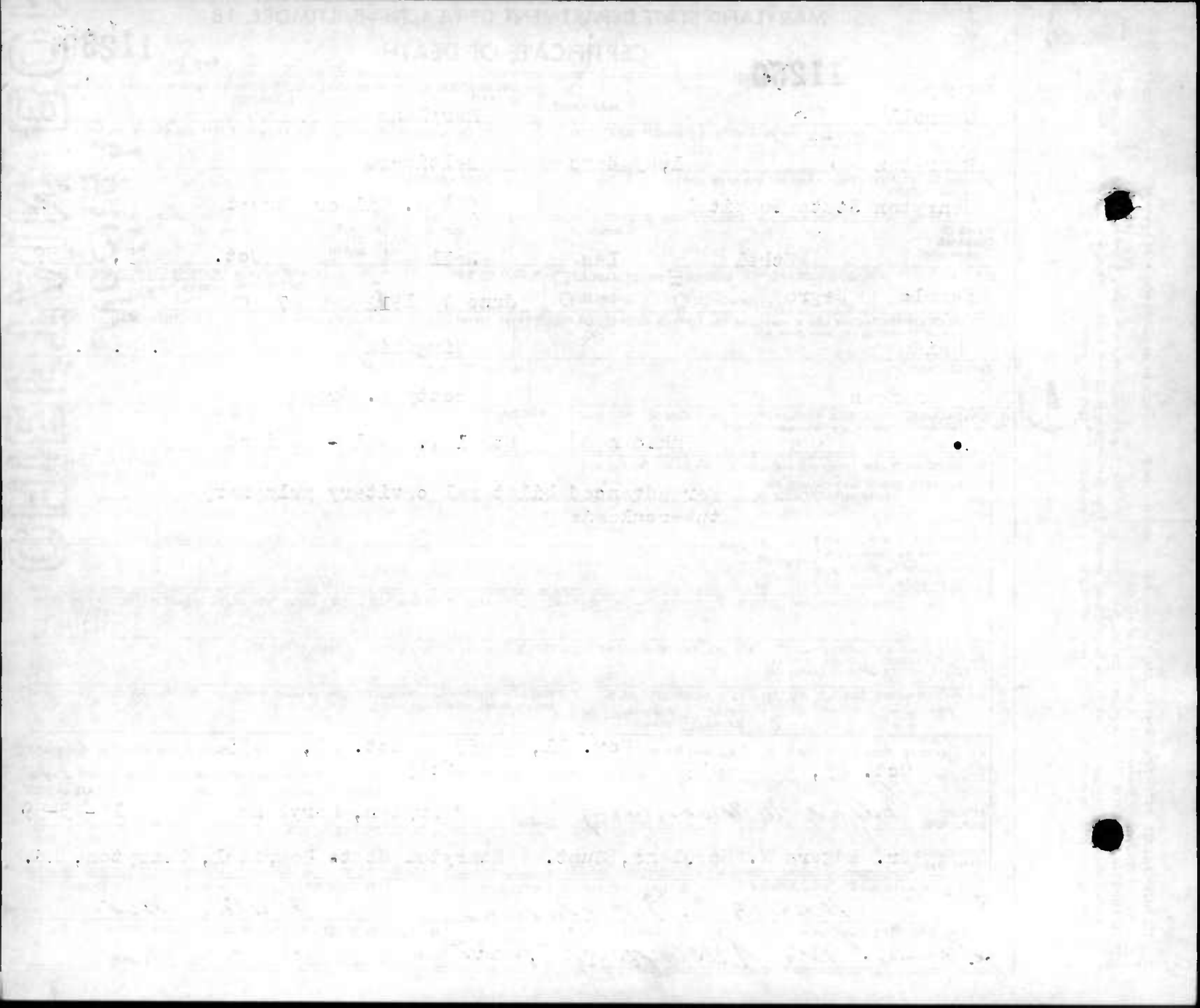
| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>✓</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u> | | | | c. LENGTH OF STAY IN lb <u>1443 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Henryton State Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Lee</u> Last <u>Hall</u> | | | | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>25</u> Year <u>19 59</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June ? 1912</u> | |
| 9. AGE (In years last birthday) <u>47</u> yrs. | | IF UNDER 1 YEAR Months <u>47</u> Days <u>47</u> Hours <u>47</u> Min. <u>47</u> | | IF UNDER 24 HRS. Months <u>47</u> Days <u>47</u> Hours <u>47</u> Min. <u>47</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u> | | 11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Betty A. Gross</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wgr or dates of service) <u>N.</u> | | | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | | |
| INFORMANT <u>Ethel L. Hall - Patient</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far advanced bilateral cavitory pulmonary tuberculosis</u> DUE TO <u>tuberculosis</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO <u></u> DUE TO <u></u> DUE TO <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X</u> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Nov. 11, 1955</u> to <u>Oct. 25, 1959</u> that I last saw the deceased alive on <u>Oct. 25, 1959</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Edgars M. Maculans</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Henryton, Maryland</u> DATE SIGNED <u>10-25-59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>10-25-59</u> | | <u>10-25-59</u> | | <u>Dr. Auburn</u> | | <u>Balto Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Samuel W. Sullivan of Balto</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>OCT 28 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur J. ...</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58



11261

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u> | | c. LENGTH OF STAY IN 1b <u>11 years</u> | |
| d. STREET ADDRESS <u>Greenville Road</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Martha Jane HAMRICK</u> | | 4. DATE OF DEATH <u>October 1 1959</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 3, 1894</u> |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Edward Hamrick</u> | | Address <u>Sykesville, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, Coronary 7</u> <u>157x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>pancreas generalized metastasis -</u> DUE TO (c) <u>Anemia, pleural effusion.</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1956</u> <u>To</u> <u>1 Oct 59</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>1850</u> , 19 <u>59</u> , to <u>1 Oct 1959</u> , that I last saw the deceased alive on <u>1 Oct 1959</u> , and that death occurred at <u>1:05 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D. | | ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u> DATE SIGNED <u>1 Oct 59</u> | |
| PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u> | | <u>Sykesville, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10-4-59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Craigsville</u> | 22d. LOCATION (City, town, or county) (State) <u>Craigsville W. Va.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight</u> ADDRESS <u>Sykesville, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE OCT 5 1959</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur A. Haight</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use in the burial, cremation, or removal, and in any event within 72 hours after death.

11262

CERTIFICATE OF DEATH

Reg. Dist. No.

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|--|-----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> | | c. LENGTH OF STAY IN 1b <u>75 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>GEORGE - M - HELFRICH</u> First Middle Last | | 4. DATE OF DEATH <u>Oct 12 1959</u> Month Day Year | |
| 5. SEX <u>M</u> | 6. COLOR OF RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-7-1873</u> |
| 9. AGE (In years last birthday) <u>85</u> Yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>General</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Peter Helfrich</u> | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-12-1490</u> | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Coronary Thromboses</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 yrs.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>- 10 MIN</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>47</u> , to <u>Oct 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 3</u> , 19 <u>59</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W H Foard</u> | | ADDRESS (Street, city or town, state) <u>Manchester, MD</u> DATE SIGNED <u>10/12/59</u> | |
| PHYSICIAN'S NAME (Type) <u>W. H. FOARD M.D.</u> | | <u>Manchester, MD</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10-14-59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran</u> | 22d. LOCATION (City, town, or county) (State) <u>Manchester, Carroll Co MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin C. Tipton</u> | | 24a. REC'D BY REGISTRAR <u>Arthur S. Hanna</u> DATE <u>OCT 14 '59</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, mostly illegible text from a death certificate form, including fields for name, age, sex, date of death, and cause of death.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 14 FilmG251 11-9-59 et
11240
CERTIFICATE OF DEATH

Reg. Dist. No. 11242

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|---|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster, Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sardans Rest Home</u> | | d. STREET ADDRESS <u>178 E. Green St.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>BLANCHE</u> <u>HIPSLEY</u> | | 4. DATE OF DEATH Month Day Year <u>Oct.</u> <u>29</u> <u>1959</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 13 1879</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Alfred W. Buckingham</u> | | 14. MOTHER'S MAIDEN NAME <u>Martha Hood</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>Elmer Elmer</u> | | Address <u>178 E. Green St. Westminster, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Renal disease</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension & decompensation</u> DUE TO (c) <u>Arterio Sclerosis - genl</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>several</u> <u>4-10</u> <u>several</u> <u>4-10</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>Oct 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 27</u> , 19 <u>59</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W. Glenn Spicher</u> M.D. | | ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> | |
| DATE SIGNED <u>10/29/59</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Oct. 31, 59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myer, Jr.</u> | | ADDRESS <u>Westminster, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>NOV 2 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11263

CERTIFICATE OF DEATH

11243

Reg. Dist. No.

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|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 4 1/2 yrs. 12 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First James Middle Hogan Last Hogan | | 4. DATE OF DEATH Month October Day 2, Year 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1872 |
| 9. AGE (In years last birthday) 87 yrs. | | 10. IF UNDER 1 YEAR Months 87 Days 12 Hours 0 Min. 0 | 11. IF UNDER 24 HRS. Months 0 Days 12 Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beggar | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Unknown | | 12. CITIZEN OF WHAT COUNTRY? Unknown | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Springfield Hospital Records | | Address Springfield Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia. 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with alcohol intoxication without qualifying phrase. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 7, 19 55 , to October 2, 19 59 , that I last saw the deceased alive on October 2, 19 59 , and that death occurred at 10:30 PM from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Agustin del Campo M.D. | | ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/3/59 | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | SYKESVILLE, MARYLAND | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-6-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 22d. LOCATION (City, town or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ruth H. Wright | | 24. REC'D BY REGISTRAR DATE OCT 7 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kneass | | | |

CERTIFICATE OF DEATH

11508

Maryland

Baltimore

Physician

Non-Resident Physician

Hospital

John

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John

John

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John

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CERTIFICATE OF DEATH

Reg. Dist. No.

11264

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|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 4yrs.5mos.7days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Lydia Middle Isadore Last Love | | 4. DATE OF DEATH Month October Day 26 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 20, 1874 |
| 9. AGE (In years last birthday) 85 yrs. | | 10. IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min. | 11. IF UNDER 24 HRS. Months 85 Days 85 Hours 85 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME David Love | | 14. MOTHER'S MAIDEN NAME Eleanor Duff | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculous pneumonia 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction. Fracture, right tibia and right fibula. Pulmonary tuberculosis. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 19, 1955 , to October 26, 1959 , that I last saw the deceased alive on October 26, 1959 , and that death occurred at 4:20PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Agustin del Campo M.D. | | ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/26/59 | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | Sykesville, Maryland. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Oct. 29, 1959 | 22c. NAME OF CEMETERY OR CREMATORY Brookview Cem. | 22d. LOCATION (City, town, or county) (State) Rising Sun, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Thomas E. McMiller | | 24a. REC'D BY REGISTRAR OCT 29 '59 | |
| ADDRESS Rising Sun, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11265

CERTIFICATE OF DEATH

Reg. Dist. No.

11245

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|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 11mths.5days | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia, Maryland d. STREET ADDRESS 15X-2 | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Earl Kindley Linthicum | | 4. DATE OF DEATH Month Day Year October 25 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 22, 1893 |
| 9. AGE (In years last birthday) yrs. 65 | | 10. IF UNDER 1 YEAR Months Days Hours Min. 65 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer and Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY Farmer & Music Teacher Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? American | |
| 13. FATHER'S NAME Miel Linthicum | | 14. MOTHER'S MAIDEN NAME Mary Prudum | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown | | 16. SOCIAL SECURITY NO. 220-34-0907 | |
| 17. INFORMANT Mrs Ada M. Linthicum, Monrovia, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Cerebro- Vascular accident DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH days | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10-8 , 19 59 , to 10/25 , 19 59 , that I lost saw the deceased alive on 10/25 , 19 59 , and that death occurred at 11:30AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Francisco Magro | | DATE SIGNED Springfield State Hospital | |
| PHYSICIAN'S NAME (Type) Magro | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/27/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Montgomery Meth. | | 22d. LOCATION (City, town, or county) (State) Clagettville Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John L. Mohan | | 24a. REC'D BY REGISTRAR DATE OCT 28 '59 | |
| ADDRESS Damascus, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur S. House | |

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

11246

11266

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| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--New Windsor | | c. LENGTH OF STAY IN lb 3 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle BENJAMIN Last LONG | | 4. DATE OF DEATH Month OCT. Day 23 Year 1959 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-9-1888 |
| 9. AGE (In years last birthday) 71 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Thomas Long | | 14. MOTHER'S MAIDEN NAME Martha Black | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 217-36-4084 | |
| 17. INFORMANT Mrs. Bessie Long, | | Address same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.1 Aortic stenosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary insufficiency | | | INTERVAL BETWEEN ONSET AND DEATH years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from August 13 1959 , to October 23 1959 , that I last saw the deceased alive on Oct 21 , 1959, and that death occurred at 3:39 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE J. H. Cariscofe | | ADDRESS (Street, city or town, state) 118 S. Main St., Union Bridge | |
| PHYSICIAN'S NAME (Type) J. H. CARICOFE | | DATE SIGNED 10/23/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 10-26-1959 | 22c. NAME OF CEMETERY OR CREMATORY Locust Grove | 22d. LOCATION (City, town, or county) (State) Frederick Co. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. M. WALTZ, | | 24a. REC'D BY REGISTRAR OCT 27 '59 | |
| ADDRESS Winfield, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

11518

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11247

Reg. Dist. No.

11267

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore City</i> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sylkesville</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 14, Md</i> | |
| c. LENGTH OF STAY IN 1b <i>120 days</i> | | 3. NAME OF DECEASED (Type or print) First Middle Last <i>THOMAS LUCCHESI</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i> | | d. STREET ADDRESS <i>2813 Harview Trc</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4. DATE OF DEATH <i>10</i> Month <i>24</i> Day Year <i>19 59</i> | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>11-8-1902</i> |
| 9. AGE (In years last birthday) <i>56</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS. Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>barber</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>barber</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Italy</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S. citizen</i> | |
| 13. FATHER'S NAME <i>Cornelio</i> | | 14. MOTHER'S MAIDEN NAME <i>Patricia Corbelli</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>0</i> | | 16. SOCIAL SECURITY NO. <i>215-05-1837</i> | |
| 17. INFORMANT <i>wife</i> | | Address <i>2813 Harview Trc, Baltimore 14</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic changes which led to a CVA</i> DUE TO <i>6 years ago</i> (c) <i>patient was paralyzed for the last 6 years.</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>15 minutes</i> <i>years</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>patient was paralyzed for the last 6 years.</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>June 27</i> , 19 <i>58</i> , to <i>Oct 24, 1959</i> , that I last saw the deceased alive on <i>Oct 23</i> , 19 <i>58</i> , and that death occurred at <i>2:15</i> P. M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Heinz H. Klaatich</i> M.D. | | ADDRESS (Street, city or town, state) <i>Springfield State Hospital</i> | |
| PHYSICIAN'S NAME (Type) <i>HEINZ H. KLAATSCH</i> | | DATE SIGNED <i>10/24/1959</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | 22b. DATE THEREOF <i>10-27-59</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem.</i> | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> | | ADDRESS <i>5305 Harford Rd</i> | |
| 24a. REC'D BY REGISTRAR <i>OCT 27 '59</i> | | 24b. REGISTRAR'S SIGNATURE <i>Carlton E. ...</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLAIN BOND

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

| | | | | | | | |
|---------------------------------|--|-----------------------------|--|-------------------------------|--|----------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of death | |
| 5. Place of death | | 6. Cause of death | | 7. Manner of death | | 8. Signature of physician | |
| 9. Signature of registrar | | 10. Signature of undertaker | | 11. Signature of funeral home | | 12. Signature of cemetery | |
| 13. Signature of health officer | | 14. Signature of coroner | | 15. Signature of jury | | 16. Signature of witnesses | |
| 17. Signature of family | | 18. Signature of neighbors | | 19. Signature of friends | | 20. Signature of community | |
| 21. Signature of church | | 22. Signature of school | | 23. Signature of business | | 24. Signature of other | |
| 25. Signature of other | | 26. Signature of other | | 27. Signature of other | | 28. Signature of other | |
| 29. Signature of other | | 30. Signature of other | | 31. Signature of other | | 32. Signature of other | |
| 33. Signature of other | | 34. Signature of other | | 35. Signature of other | | 36. Signature of other | |
| 37. Signature of other | | 38. Signature of other | | 39. Signature of other | | 40. Signature of other | |
| 41. Signature of other | | 42. Signature of other | | 43. Signature of other | | 44. Signature of other | |
| 45. Signature of other | | 46. Signature of other | | 47. Signature of other | | 48. Signature of other | |
| 49. Signature of other | | 50. Signature of other | | 51. Signature of other | | 52. Signature of other | |
| 53. Signature of other | | 54. Signature of other | | 55. Signature of other | | 56. Signature of other | |
| 57. Signature of other | | 58. Signature of other | | 59. Signature of other | | 60. Signature of other | |
| 61. Signature of other | | 62. Signature of other | | 63. Signature of other | | 64. Signature of other | |
| 65. Signature of other | | 66. Signature of other | | 67. Signature of other | | 68. Signature of other | |
| 69. Signature of other | | 70. Signature of other | | 71. Signature of other | | 72. Signature of other | |
| 73. Signature of other | | 74. Signature of other | | 75. Signature of other | | 76. Signature of other | |
| 77. Signature of other | | 78. Signature of other | | 79. Signature of other | | 80. Signature of other | |
| 81. Signature of other | | 82. Signature of other | | 83. Signature of other | | 84. Signature of other | |
| 85. Signature of other | | 86. Signature of other | | 87. Signature of other | | 88. Signature of other | |
| 89. Signature of other | | 90. Signature of other | | 91. Signature of other | | 92. Signature of other | |
| 93. Signature of other | | 94. Signature of other | | 95. Signature of other | | 96. Signature of other | |
| 97. Signature of other | | 98. Signature of other | | 99. Signature of other | | 100. Signature of other | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11268
CERTIFICATE OF DEATH

11248

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital | | d. STREET ADDRESS 416 S. Spring Street | |
| 3. NAME OF DECEASED (Type or print) First Hattie Middle Catherine Last Mitchell | | 4. DATE OF DEATH Month October Day 12 Year 1959 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 30, 1913 |
| 9. AGE (In years last birthday) 46 yrs. | | IF UNDER 1 YEAR Months 46 Days 46 Hours 46 Min. 46 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Mitchell | | 14. MOTHER'S MAIDEN NAME Ida Stewart | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 239-05-8530 | |
| 17. INFORMANT Hattie C. Mitchell - 416 S. Spring. | | Address Balto., Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral cavitory pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) 002 X DUE TO (c) 002 X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002 X | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August 26, 1959 , to October 12, 1959 , that I last saw the deceased alive on October 12, 1959 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 10-12-59 ACTUAL SIGNATURE Edgars M. Maculans M.D. PHYSICIAN'S NAME (Type) Edgars M. Maculans, M.D. Henryton State Hospital, Henryton, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10/15/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY EVERGREEN | | 22d. LOCATION (City, town, or county) (State) WINSTON SALEM, N.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ROBINSON FUNERAL HOME - WINSTON SALEM | | 24a. REC'D BY REGISTRAR OCT 14 '59 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | | | |

CERTIFICATE OF DEATH

11249

Reg. Dist. No.

11241

| | | | | | | | |
|---|-------------------------------|---|--------------------------------------|--|-----------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Westminster</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>43 Westmoreland St.</u> | | | | e. STREET ADDRESS <u>1 43 Westmoreland St.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY EDWIN NAGLE, JR.</u> | | | | 4. DATE OF DEATH Month Day Year <u>Oct. 31 1959</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 2, 1886</u> | 9. AGE (In years last birthday) <u>73</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Food Machinery</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland (Balt.)</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Harry Edwin Nagle</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Frances Virginia Adair</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u> | | 16. SOCIAL SECURITY NO. <u>219-12-1000</u> | | 17. INFORMANT <u>Mrs. Hazel M. Warner, 43 Westmoreland St. Westminster, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis (chr)</u> <u>Hypertension (chr)</u> <u>241X</u> DUE TO <u>Asthma -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uranner -</u> (c) <u></u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u> <u>1 wk.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 1930</u> to <u>Oct 31, 1959</u> , that I last saw the deceased alive on <u>Oct 31, 1959</u> , and that death occurred at <u>6:40 P.</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Wm. C. Jennette</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>103 E. Main Westminster Md</u> DATE SIGNED <u>11-2-59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Wm. Carl Jennings MD</u> | | | | <u>Westminster Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11/3/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Westminster Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster Md.</u> ADDRESS <u></u> | | | | 24a. REC'D BY REGISTRAR <u>DATE</u> <u>3 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Caroline S. Knease</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for to burial, cremation, or removal, and in any event within 72 hours after death.

11861

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH ONE 10

11861

| | | |
|--|--|---|
| <p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. CAUSE OF DEATH</p> <p>8. PLACE OF DEATH</p> <p>9. DATE OF DEATH</p> <p>10. TIME OF DEATH</p> <p>11. SIGNATURE OF DECEASED</p> <p>12. SIGNATURE OF WITNESSES</p> <p>13. SIGNATURE OF PHYSICIAN</p> <p>14. SIGNATURE OF REGISTRAR</p> | | <p>15. NAME OF DECEASED</p> <p>16. SEX</p> <p>17. AGE</p> <p>18. DATE OF BIRTH</p> <p>19. PLACE OF BIRTH</p> <p>20. OCCUPATION</p> <p>21. CAUSE OF DEATH</p> <p>22. PLACE OF DEATH</p> <p>23. DATE OF DEATH</p> <p>24. TIME OF DEATH</p> <p>25. SIGNATURE OF DECEASED</p> <p>26. SIGNATURE OF WITNESSES</p> <p>27. SIGNATURE OF PHYSICIAN</p> <p>28. SIGNATURE OF REGISTRAR</p> |
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MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH ONE 10

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF REGISTRAR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11269

CERTIFICATE OF DEATH

Reg. Dist. No.

11250

| | | | | | | | |
|--|------------------------------|---|---------------------------------------|--|---|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RAILROAD STREET</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MILDRED OTTO NUSBAUM</u> | | | | 4. DATE OF DEATH Month Day Year <u>OCT 2 19 59</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>FEB 5-1903</u> | 9. AGE (In years last birthday) <u>56</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>CHARLES OTTO</u> | | | | 14. MOTHER'S MAIDEN NAME <u>NORA EYLER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>RUSSELL NUSBAUM</u> Address <u>UNION BRIDGE MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anaplastic carcinoma, probably</u> <u>162.1</u> DUE TO <u>bronchogenic in origin</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>8 mo.</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardiovascular disease</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>59</u> , to <u>Oct 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 1</u> , 19 <u>59</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1185 Main, Union Bridge, Md.</u> DATE SIGNED <u>10/2/59</u> ACTUAL SIGNATURE <u>J. H. Caricoffe</u> PHYSICIAN'S NAME (Type) <u>J H CARICOFE</u> <u>UNION BRIDGE MD</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>OCT 4-1959</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>MT VIEW</u> | | 22d. LOCATION (City, town, or county) (State) <u>UNION BRIDGE MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>D. Hartzler & Sons Union Bridge, Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>OCT 6 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | |

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. NAME OF DECEASED <i>John Doe</i> | | 2. PLACE OF BIRTH <i>New York</i> | |
| 3. DATE OF BIRTH <i>Jan 1, 1880</i> | | 4. SEX <i>Male</i> | |
| 5. OCCUPATION <i>Teacher</i> | | 6. MARITAL STATUS <i>Married</i> | |
| 7. PLACE OF DEATH <i>Home</i> | | 8. CAUSE OF DEATH <i>Heart Disease</i> | |
| 9. DATE OF DEATH <i>Dec 15, 1910</i> | | 10. TIME OF DEATH <i>10:00 AM</i> | |
| 11. SIGNATURE OF DECEASED <i>John Doe</i> | | 12. SIGNATURE OF WITNESS <i>John Doe</i> | |
| 13. SIGNATURE OF PHYSICIAN <i>John Doe</i> | | 14. SIGNATURE OF CLERK <i>John Doe</i> | |
| 15. SIGNATURE OF REGISTRAR <i>John Doe</i> | | 16. SIGNATURE OF JUDGE <i>John Doe</i> | |
| 17. SIGNATURE OF SHERIFF <i>John Doe</i> | | 18. SIGNATURE OF CORONER <i>John Doe</i> | |
| 19. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 20. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 21. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 22. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 23. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 24. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 25. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 26. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 27. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 28. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 29. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 30. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 31. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 32. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 33. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 34. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 35. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 36. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 37. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 38. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 39. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 40. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 41. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 42. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 43. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 44. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 45. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 46. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 47. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 48. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 49. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 50. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 51. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 52. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 53. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 54. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 55. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 56. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 57. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 58. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 59. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 60. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 61. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 62. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 63. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 64. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 65. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 66. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 67. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 68. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 69. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 70. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 71. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 72. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 73. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 74. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 75. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 76. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 77. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 78. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 79. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 80. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 81. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 82. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 83. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 84. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 85. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 86. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 87. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 88. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 89. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 90. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 91. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 92. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 93. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 94. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 95. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 96. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |
| 97. SIGNATURE OF DEPUTY JUDGE <i>John Doe</i> | | 98. SIGNATURE OF DEPUTY REGISTRAR <i>John Doe</i> | |
| 99. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i> | | 100. SIGNATURE OF DEPUTY CORONER <i>John Doe</i> | |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11251

11270

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine | | c. LENGTH OF STAY IN 1b 10 wks | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weitzel Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Julia Middle L. Last Pickett | | 4. DATE OF DEATH Month Oct. Day 17 Year 19 59 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-17-1900 |
| 9. AGE (In years last birthday) 59 yrs. | | 10. IF UNDER 1 YEAR Months 59 Days 17 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Harry Gosnell | | 14. MOTHER'S MAIDEN NAME Marian Gosnell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 215-14-1638 | |
| 17. INFORMANT Mr. Herbert Pickett, same | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 356.1 Amyotrophic Lateral Sclerosis, DUE TO Cardiac failure, Anasarca, Gangrene Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) due to (c) due to ulcer on stomach & hp. Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 1956 to 17 Oct 59 | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 19 59 , 19 1959 , to 17 Oct 1959 , that I last saw the deceased alive on 17 Oct 1959 , and that death occurred at 6:00 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Howard E. Hall | | ADDRESS (Street, city or town, state) Applerville, Md | |
| PHYSICIAN'S NAME (Type) HOWARD E. HALL | | DATE SIGNED 18 Oct 59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10-20-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Morgan Chapel | | 22d. LOCATION (City, town, or county) (State) Carroll Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, | | ADDRESS Winfield, Md. | |
| 24a. REC'D BY REGISTRAR DATE OCT 21 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

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CERTIFICATE OF DEATH

11270

11270

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

11270

11-17-1900

WHITE

MALE

MALE

BARBARA BONNELL

BARBARA BONNELL

11-17-1900

11-17-1900

DO

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11-17-1900

11-17-1900

11-17-1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

11271

Item 1 Film G251 11-13-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

11252

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 1M 20D | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 3222 Putty Hill Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Robert Middle Malcolm Last PYLE | | 4. DATE OF DEATH Month October Day 31 Year 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 3-12-1879 |
| 9. AGE (In years last birthday) 80 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary engineer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles Westley Pyle | | 14. MOTHER'S MAIDEN NAME Amanda McComas | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Records of Springfield State Hospital | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease incl. coron. disease DUE TO (c) Hypochromic anemia (due to malignancy?) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS ass. with cerebral arteriosclerosis with psychotic reaction 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 10-6-1959 , to 10-31-1959 , that I last saw the deceased alive on 10-31-1959 , and that death occurred at 8.15P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfields State Hospital 11-1-59 | | | |
| ACTUAL SIGNATURE Myron Nizankowski M.D. Springfields State Hospital | | | |
| PHYSICIAN'S NAME (Type) Myron Nizankowski Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 11-4-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery. | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight Inc. 6009 Harford Rd. 14. | | 24a. REC'D BY REGISTRAR NOV 3 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Carlton S. Hunt | |

CERTIFICATE OF DEATH

MAINTAIN STATE DEPARTMENT OF HEALTH - BASTROP, LA

11571

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

.. 11571 ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11253

11272

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 7 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Gustav Middle Reinhardt Last | | | | 4. DATE OF DEATH Month October Day 5 Year 19 59 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH August 28, 1865 | |
| 9. AGE (In years last birthday) yrs. 94 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 11. BIRTHPLACE (State or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? Naturalized | |
| 13. FATHER'S NAME Andrew Reinhardt | | | | 14. MOTHER'S MAIDEN NAME Minnie Reinhardt | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 215-22-8906A | | INFORMANT Address Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic heart disease DUE TO (c) C.B.S. with senile brain disease with psychotic reaction | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Days Years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 27, 1955 , to October 5, 1959 , that I last saw the deceased alive on October 5, 1959 , and that death occurred at 8:20P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 10/6/59 | | | | | | | |
| ACTUAL SIGNATURE <i>Julian Radcykowycz</i> | | M.D. Springfield State Hospital 10/6/59 | | | | | |
| PHYSICIAN'S NAME (Type) Julian Radcykowycz, M.D. | | Sykesville, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10-7-59 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) 5829 Ritchie Highway, Zone 25 | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street | | | | ADDRESS 1217 St. Paul Street | | 24a. REC'D BY REGISTRAR DATE OCT 7 1959 | |
| | | | | 24b. REGISTRAR'S SIGNATURE <i>William Cook</i> | | | |

CERTIFICATE OF DEATH

11372

| | | | |
|------------------------|--|-------------------------------|--|
| Name of Deceased | | John J. Doe | |
| Age | | 45 | |
| Sex | | Male | |
| Date of Birth | | 1910-01-15 | |
| Place of Birth | | New York, N.Y. | |
| Cause of Death | | Heart Disease | |
| Date of Death | | 1955-10-20 | |
| Place of Death | | St. Mary's Hospital, New York | |
| Signature of Physician | | [Signature] | |
| Signature of Registrar | | [Signature] | |
| Date of Registration | | 1955-10-25 | |
| Place of Registration | | New York, N.Y. | |

11273

CERTIFICATE OF DEATH

11254

Reg. Dist. No.

| | | | | | | | |
|---|--|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marquette</u> | | | | c. LENGTH OF STAY IN 1b <u>5 months</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u> | | | | d. STREET ADDRESS <u>R. MAIN</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Rachel</u> Middle <u>Roesel</u> Last <u>Roesel</u> | | | | 4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1959</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 1, 1864</u> | |
| 9. AGE (In years last birthday) <u>95</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Stensbury</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Eliza Pennington</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>0-70</u> | | 17. INFORMANT Address <u>Mrs Mary Williams, HAMPSTEAD MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Cardio-Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH ? |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | | 20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from <u>June 1, 1959</u> , to <u>October 31, 1959</u> , that I last saw the deceased alive on <u>October 30, 1959</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Hampstead, Md</u> DATE SIGNED <u>10-31-59</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u> | | | | ADDRESS <u>HAMPSTEAD Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>11-3-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Buried Ridge</u> | | 22d. LOCATION (City, town, or county) (State) <u>Pikeville Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. A. Tipton</u> ADDRESS <u>Hampstead Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>NOV 3 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar or to burial, cremation, or removal, and in any event within 72 hours after death.

12
1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11274

CERTIFICATE OF DEATH

11255

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 3mos.8days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Benjamin Middle Harry Last Schaff | | | | 4. DATE OF DEATH Month October Day 25 Year 1959 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 15, 1887 | | 9. AGE (In years last birthday) yrs. 71 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Dye Maker | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Stover S. Schaff | | | | 14. MOTHER'S MAIDEN NAME Maggie C. Mowen | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-09-4940-A | | INFORMANT Address Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis without qualifying phrase. Old infarct in right side of brain due to arteriosclerosis. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Days Years Years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 17, 1959 , to October 25, 1959 , that I last saw the deceased alive on October 25, 1959 , and that death occurred at 7:15P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Agustin del Campo M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 10/26/59 | | | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/27/59 | | 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Hagerstown Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horment | | | | ADDRESS Hagerstown, Md. | | 24a. REC'D BY REGISTRAR DATE OCT 28 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11275

CERTIFICATE OF DEATH

Reg. Dist. No.

11256

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|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 15 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First HENRY Middle GOTTLIEB Last SCHMIDT | | | | 4. DATE OF DEATH Month October Day 8 Year 1959 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4-12-81 | |
| 9. AGE (In years last birthday) 78 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer | | | | 10b. KIND OF BUSINESS OR INDUSTRY newspaper | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Jacob Schmidt | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Fischer | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 213-03-3134 | | | |
| 17. INFORMANT Records, Springfield State Hospital | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Generalized Arteriosclerosis DUE TO (c) Acute gangrenous colitis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Years Years Days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hospital | |
| 20f. (City or town) Sykesville | | | | (County) (State) | | | |
| 21. I certify that I attended the deceased from September 23 1959 to October 8 1959 , that I last saw the deceased alive on October 8 1959 , and that death occurred at 4:40 A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Agustin del Campo | | | | ADDRESS (Street, city or town, state) Springfield State Hospital | | | |
| DATE SIGNED 10-8-59 | | | | | | | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M. D. | | | | SYKESVILLE, MARYLAND | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF 10-12-59 | | 22c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum | | 22d. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck | | | | ADDRESS 5305 Harford Rd | | 24a. REC'D BY REGISTRAR DATE OCT 13 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | | | |

2

MEDICAL CERTIFICATION

Figure 1

1372

17-55-1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11276

CERTIFICATE OF DEATH

11257

Reg. Dist. No.

| | | | |
|--|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamber</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamber</u> | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | |
| d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>HORACE</u> First <u>L.</u> Middle <u>SHIPLEY</u> Last | | 4. DATE OF DEATH <u>OCTOBER 2</u> Month <u>2</u> Day <u>1959</u> Year | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 22 1871</u> |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Rew's Shipley</u> | | 14. MOTHER'S MAIDEN NAME <u>Christine Ambusight</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Mrs. Harold Necken - Hinksburg, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RECTAL HEMORRAGE</u> DUE TO <u>154X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF RECTUM</u> DUE TO (c) <u>UNKNOWN</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC C.V. DISEASE</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept. 29, 1959</u> , to <u>Oct. 2, 1959</u> , that I last saw the deceased alive on <u>Oct. 2, 1959</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Martin E. Strobel</u> | | ADDRESS (Street, city or town, state) <u>48 MAIN ST. REISTERSTOWN</u> DATE SIGNED <u>10/2/59</u> | |
| PHYSICIAN'S NAME (Type) <u>MARTIN E. STROBEL</u> | | M.D. <u>MARYLAND</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10-5-59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Providence</u> | | 22d. LOCATION (City, town, or county) (State) <u>Hamber, Carroll, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> | | ADDRESS <u>Edysville, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>OCT 5 2 59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Carroll & Hume</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file or for a burial, cremation, or removal of the remains. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

VS. A1SME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11277 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11258

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Sykesville | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Sykesville | |
| 3. NAME OF DECEASED (Type or print) First MATILDA Middle A. Last SHIPLEY | | 4. DATE OF DEATH Month Oct Day 27 Year 1959 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-27-1897 |
| 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY school | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Almer Shipley | | 14. MOTHER'S MAIDEN NAME Mary Jane Barnes | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ? | |
| 17. INFORMANT Miss Lillian Shipley, Westminster, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 421.4 DUE TO Valvular Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 years DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 203 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. — 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Julius Chepko | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) JULIUS CHEPKO | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 10/23/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10-24-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Ebenezer | | 22d. LOCATION (City, town, or county) (State) Carroll Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, | | ADDRESS Winfield, Md. | |
| 24a. REC'D BY REGISTRAR DATE OCT 26 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Huns | |

TO THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11259

11278

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 4 1/2 yrs. 5 mos. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS None | |
| 3. NAME OF DECEASED (Type or print) First Fred Middle O. Last Sprecher | | 4. DATE OF DEATH Month October Day 13 Year 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 2, 1876 |
| 9. AGE (In years last birthday) 83 yrs. | | 10. IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. | 11. IF UNDER 24 HRS. Months 83 Days 83 Hours 83 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY TANNER | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME J. Irwin Sprecher | | 14. MOTHER'S MAIDEN NAME Annie Bowles | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. NONE | |
| 17. INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the prostate with metastasis to the 177X DUE TO bronchi and pelvic tissue Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple lung abscesses with bronchopneumonia DUE TO Weeks (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S., assoc. with cerebral arteriosclerosis with psychosis. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 7, 1955 to October 13, 1959 , that I last saw the deceased alive on October 13, 1959 , and that death occurred at 6:50 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Agustin del Campo M.D. | | ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 10/14/59 | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | Sykesville, Maryland | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial 10/14/59 | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Paul's Church | | 22d. LOCATION (City or town, or county) (State) Washington Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.D. Norment | | ADDRESS Hagerstown, Md. | |
| 24. REC'D BY REGISTRAR OCT 16 '59 | | 24b. REGISTRAR'S SIGNATURE Charles S. Hanna | |

CERTIFICATE OF DEATH

11378

Full Name of Deceased: [Illegible]
Date of Birth: [Illegible]
Sex: [Illegible]

Place of Birth: [Illegible]
Date of Death: [Illegible]
Cause of Death: [Illegible]

Signature of Doctor: [Illegible]
Signature of Registrar: [Illegible]

Signature of Deceased: [Illegible]
Signature of Next of Kin: [Illegible]

Signature of Medical Officer: [Illegible]
Signature of Health Officer: [Illegible]

Signature of Registrar: [Illegible]
Signature of Deceased: [Illegible]

Signature of Medical Officer: [Illegible]
Signature of Health Officer: [Illegible]

Signature of Registrar: [Illegible]
Signature of Deceased: [Illegible]

Signature of Medical Officer: [Illegible]
Signature of Health Officer: [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11279

CERTIFICATE OF DEATH

Reg. Dist. No.

11260

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R. D. 1 | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Fannie Middle Maude Last Stonesifer | | 4. DATE OF DEATH Month October Day 13 Year 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/23/1889 |
| 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife—Housework | | 10b. KIND OF BUSINESS OR INDUSTRY In her own home | 11. BIRTHPLACE (State or foreign country) Carroll Co., Md. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Washington Myers | |
| 14. MOTHER'S MAIDEN NAME Mary Jane Black | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT John T. Stonesifer, Westminster, Md. R.D.1 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) 10 years | | INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept , 19 57 , to Oct , 19 59 , that I last saw the deceased alive on Oct 13 , 19 59 , and that death occurred at 9:45 P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Leah Marshall | | ADDRESS (Street, city or town, state) Littlestown, Pa | |
| PHYSICIAN'S NAME (Type) Richard A. Little | | DATE SIGNED OCT 15 '59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/16/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery | | 22d. LOCATION (City, town, or county) (State) Pleasant Valley, Carroll Co., Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hays | |

11200

CERTIFICATE OF DEATH

11272

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

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|--|--|--|--|
| NAME OF DECEASED WESTON, John A. | | DATE OF BIRTH 1892 | |
| PLACE OF BIRTH BALTIMORE, MD | | DATE OF DEATH 1912 | |
| OCCUPATION Carpenter | | CAUSE OF DEATH Tuberculosis | |
| MANNER OF DEATH Natural | | PLACE OF DEATH BALTIMORE, MD | |
| NAME OF PHYSICIAN Dr. J. H. Smith | | NAME OF FUNERAL HOME The Baltimore Funeral Home | |
| NAME OF NEXT OF KIN Mrs. J. A. Weston | | NAME OF MINISTER Rev. J. H. Smith | |
| NAME OF BURIAL PLACE Greenwood Cemetery | | NAME OF CITY BALTIMORE, MD | |
| NAME OF COUNTY BALTIMORE | | NAME OF STATE MARYLAND | |
| NAME OF DECEASED WESTON, John A. | | DATE OF BIRTH 1892 | |
| PLACE OF BIRTH BALTIMORE, MD | | DATE OF DEATH 1912 | |
| OCCUPATION Carpenter | | CAUSE OF DEATH Tuberculosis | |
| MANNER OF DEATH Natural | | PLACE OF DEATH BALTIMORE, MD | |
| NAME OF PHYSICIAN Dr. J. H. Smith | | NAME OF FUNERAL HOME The Baltimore Funeral Home | |
| NAME OF NEXT OF KIN Mrs. J. A. Weston | | NAME OF MINISTER Rev. J. H. Smith | |
| NAME OF BURIAL PLACE Greenwood Cemetery | | NAME OF CITY BALTIMORE, MD | |
| NAME OF COUNTY BALTIMORE | | NAME OF STATE MARYLAND | |

11280

CERTIFICATE OF DEATH

Reg. Dist. No. 11261

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|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegheny</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield St. Hosp.</i> | | d. STREET ADDRESS <i>—</i> | |
| 3. NAME OF DECEASED (Type or print) <i>LYDIA</i> First <i>Bell</i> Middle <i>Strahan</i> Last | | 4. DATE OF DEATH <i>Oct.</i> Month <i>4</i> Day <i>1959</i> Year | |
| 5. SEX <i>F.</i> | 6. COLOR OR RACE <i>W.</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>2-12-86</i> |
| 9. AGE (In years last birthday) <i>73</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>nurse</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>medical</i> | 11. BIRTHPLACE (State or foreign country) <i>W. Virginia</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Isiah Riley</i> | |
| 14. MOTHER'S MAIDEN NAME <i>LYDIA Keener</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | |
| 16. SOCIAL SECURITY NO. <i>—</i> | | 17. INFORMANT <i>Hosp. records.</i> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i> <i>4221</i> DUE TO <i>Cerebral Vascular accident</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic C.V. Disease.</i> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Thyroid br. Syndrome, with cerebral arteriosclerosis & psychosis</i> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Nov. 22, 1958</i> to <i>Oct. 4, 1959</i> , that I last saw the deceased alive on <i>Oct. 3, 1959</i> , and that death occurred at <i>3:10 P.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Konstantin Weber</i> M.D. | | ADDRESS (Street, city or town, state) <i>Oak street, Sykesville, Maryland</i> | |
| PHYSICIAN'S NAME (Type) <i>KONSTANTIN WEBER</i> | | DATE SIGNED <i>OCT 7 '59</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>10/7/59</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Philos Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Westernport Maryland</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Ruth E. Silcox</i> ADDRESS <i>Cumberland Maryland</i> | | 24a. REC'D BY REGISTRAR <i>DATE OCT 7 '59</i> | 24b. REGISTRAR'S SIGNATURE <i>Carlton & Klaus</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars' names for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3.8 Film G250 10-15-59 et

11281

CERTIFICATE OF DEATH

11262

Reg. Dist. No.

| | | | |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Rural</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Rural</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print) <u>EDITH — MELVINIA — SULLIVAN</u> | | 4. DATE OF DEATH <u>Oct 8 - 1959</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1880 Sept 13 - 1919</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 13. FATHER'S NAME <u>Walter Brock</u> | | 14. MOTHER'S MAIDEN NAME <u>Rebecca Leister</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216-38-3052</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>5 yrs</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 18</u> , 19 <u>50</u> to <u>Oct 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 1</u> , 19 <u>59</u> , and that death occurred at <u>7P</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W.H. Foard</u> | | ADDRESS (Street, city or town, state) <u>Manchester, Md.</u> DATE SIGNED <u>10-9-59</u> | |
| PHYSICIAN'S NAME (Type) <u>W.H. Foard M.D.</u> | | <u>Manchester, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10-11-1959</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Germania Reformed</u> | 22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. E. Hipton</u> | | 24a. REC'D BY REGISTRAR <u>OCT 13 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Foard</u> | |

1188

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11282
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG251 11-2-59 et

CERTIFICATE OF DEATH

11263

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Sykesville | | c. LENGTH OF STAY IN lb 6 mo. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "Private Home" | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ALBERT Middle THOMAS Last | | 4. DATE OF DEATH Month OCT. Day 25, Year 19 59 | |
| 5. SEX male | 6. COLOR OR RACE negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-2-1898 |
| 9. AGE (In years last birthday) 61 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm laborer | | 10b. KIND OF BUSINESS OR INDUSTRY farming | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME George Thomas | | 14. MOTHER'S MAIDEN NAME Florence ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | |
| INFORMANT Mrs. Glayds Cook, Cooksville, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO Cerebral Hemorrhage Ruptured Cerebral Artery Hypertension + Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardio Vascular Condition | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct 14, 1959 , to Oct 25, 1959 , that I last saw the deceased alive on Oct 25, 1959 , and that death occurred at 1090 from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE MORRELL N. MASTIN | | DATE SIGNED Sykesville Md. | |
| PHYSICIAN'S NAME (Type) MORRELL N. MASTIN | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10-28-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Fairview | | 22d. LOCATION (City, town, or county) (State) Carroll Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, | | ADDRESS Winfield, Md. | |
| 24a. REC'D BY REGISTRAR DATE OCT 28 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11283

CERTIFICATE OF DEATH

11264

Reg. Dist. No.

| | | | |
|--|-----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Carroll</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <i>Oakland Road</i> | |
| 3. NAME OF DECEASED (Type or print) <i>ANNA</i> First <i>LENTHA</i> Middle <i>TROTT</i> Last | | 4. DATE OF DEATH <i>OCTOBER 19 1959</i> Month Day Year | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept. 27, 1880</i> |
| 9. AGE (In years last birthday) <i>79</i> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>William H. Trott</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Conway</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>?</i> | |
| 17. INFORMANT <i>Mrs. James E. Ebb. Sykesville, Md.</i> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>526x Acute congestive Heart Failure c</i> DUE TO <i>Pulmonary Edema - Renal Failure -</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Bronchitis - Bronchial asthma severe 25 yrs.</i> DUE TO (c) <i>Hypertrophic Arteriosclerosis - Generalized - severe</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>1 month.</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>APRIL 1, 1950</i> , to <i>OCT - 19, 1959</i> , that I last saw the deceased alive on <i>OCT 19 - 1959</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Thomas E. Wheeler</i> M.D. | | ADDRESS (Street, city or town, state) <i>3601 Chivalry Rd - Balt 9 - Md</i> | |
| PHYSICIAN'S NAME (Type) <i>THOMAS E. WHEELER</i> | | DATE SIGNED <i>10/19/59</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>10-22-59</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Oakland</i> | 22d. LOCATION (City, town, or county) (State) <i>Carroll Co., Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur A. Haight</i> ADDRESS <i>Sykesville Md.</i> | | 24a. REC'D BY REGISTRAR <i>OCT 26 '59</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use as the burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | |
|--|--|---|--|---|---|--|---|--|--|--|
| Item 1 C, Film 6250 10/22/59 iwk | | | | | | | | | | |
| 11284 CERTIFICATE OF DEATH 11265 | | | | | | | | | | |
| Reg. Dist. No. | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery ✓ | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural) | | | | | c. LENGTH OF STAY IN lb 4 yrs 2 mnts. & 29 days | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | | d. STREET ADDRESS 8011 Eastern Avenue | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Eleanor Middle S. Last Williams | | | | | 4. DATE OF DEATH Month 10 Day 15 Year 19 59 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH December 17, 1890 | | 9. AGE (In years last birthday) 68 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10b. KIND OF BUSINESS OR INDUSTRY Sou. Railroad Co | | 11. BIRTHPLACE (State or foreign country) Dist. of Columbia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 13. FATHER'S NAME Richard Scaggs | | | | | 14. MOTHER'S MAIDEN NAME Ida Fitzhugh | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | | INFORMANT Springfield State Hospital Record | | Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Broncho Pneumonia DUE TO Cerebral vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Diabetes DUE TO (c) Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition, presenile brain disease, with psychotic reaction. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition, presenile brain disease, with psychotic reaction. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | | | | | | |
| 21. I certify that I attended the deceased from 7. 10 , 19 57 , to 10 - 15 , 19 59 that I last saw the deceased alive on 10 - 15 , 19 59 , and that death occurred at 6 P. M. from the causes and on the date stated above. | | | | | | | | | | |
| ACTUAL SIGNATURE Rita S. Glavin M.D. | | | | | ADDRESS (Street, city or town, state) Springfield State H. DATE SIGNED 10-15-59 | | | | | |
| PHYSICIAN'S NAME (Type) RITA S. GLAVIN | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/17/59 | | 22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | | 22d. LOCATION (City, town, or county) (State) Washington, D. C. | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. | | | | | ADDRESS Washington, D. C. | | 24a. REC'D BY REGISTRAR OCT 19 59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

48511

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CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 3461 Chestnut Ave., Zone 11 | |
| 3. NAME OF DECEASED (Type or print) First Palmer Middle Vincent Last Yeager | | 4. DATE OF DEATH Month October Day 16, Year 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 4, 1918 |
| 9. AGE (In years lost birthday) 41 yrs. | | IF UNDER 1 YEAR Months 41 Days 16 Hours 19 Min. 59 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John V. Yeager | | 14. MOTHER'S MAIDEN NAME Edna Mae Roe | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No | | 16. SOCIAL SECURITY NO. - | |
| INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease DUE TO 410X Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) Mitral stenosis DUE TO (c) Schizophrenic reaction, catatonic type. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, catatonic type. | | | |
| INTERVAL BETWEEN ONSET AND DEATH Years Years | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from November 11, 1958 to October 16, 1959 , that I last saw the deceased alive on October 16, 1959 , and that death occurred at 10:20AM from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Francesco Magro M.D. | | DATE SIGNED 10/16/59 | |
| PHYSICIAN'S NAME (Type) Francesco Magro, M.D. | | Sykesville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 20/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Lorraine Park | | 22d. LOCATION (City, town, or county) (State) Woodlawn 7, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors 4101 Edmondson Ave. | | 24a. REC'D BY REGISTRAR DATE OCT 19 '59 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11885

1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11286

CERTIFICATE OF DEATH

11267

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 17 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Elmer Middle S. Last Young | | | | 4. DATE OF DEATH Month October Day 22 Year 1959 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH Sept. 25, 1889 | |
| 9. AGE (In years last birthday) 70 yrs. | | 10. IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME James Young | | | | 14. MOTHER'S MAIDEN NAME Martha Warner | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. - | | | |
| 17. INFORMANT Springfield Hospital Records | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Arteriosclerotic heart disease | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, hebephrenic type. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from October 5, 1959 to October 22, 1959 , that I last saw the deceased alive on October 22, 1959 , and that death occurred at 9:37 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Agustin del Campo M.D. | | | | ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/22/59 | | | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-26-59 | | 22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery | | 22d. LOCATION (City, town, or county) (State) Point of Rocks, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland | | | | 24a. REC'D BY REGISTRAR DATE OCT 27 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

11282

CERTIFICATE OF DEATH

11282

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11287

Reg. Dist. No. 11268

| | | | |
|---|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u> | | c. LENGTH OF STAY IN 1b <u>6 Mos</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First Middle Last <u>ZIMMERMAN</u> | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>14</u> Year <u>1959</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 8-1891</u> |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Howard L. Andrews</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret German</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>LeRay Nichols</u> | |
| 17. INFORMANT <u>Hagerstown Md.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>James J. Shanon</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>JAMES T MARSH</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>Oct 15-59</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>OCT 18-1959</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's</u> | | 22d. LOCATION (City, town, or county) (State) <u>Highland - Howard Co. Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward C. Tipton</u> | | ADDRESS <u>Hampstead Md</u> | |
| 24a. REC'D BY REGISTRAR <u>OCT 20 '59</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kump</u> | |

